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RESEARCH

Demographic, social and clinical variables of anticipated and experienced stigma of mental illness

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Summary

Aim. In recent years, numerous research projects were carried out involving various research centres, including Poland, to assess the subjective experience of stigma among mentally ill people. The aim of this study was to describe the anticipated and experienced stigma (Publication 2007, part I) and to analyse relationships between demographic, social and clinical factors, and anticipated and experienced stigma (part II).

Material and method. 202 patients from the Malopolska region diagnosed with schizophrenia and schizotypal syndromes (ICD 10). Average age : 40, average number of hospitalisations : 6. Angermeyer's questionnaire. The patients shared their opinions (part A) and experiences (part B) concerning stigma. To analyse inter-group comparisons Mann-Whitney U-test was used, complex relationships were assessed with forward stepwise regression.

Results. 1) Older age and living in a large town account for anticipated stigma to a limited but significant extent; a stronger experience of stigma is explained, to a limited but significant extent, with better education, lack of employment and a higher number of earlier hospitalizations. 2) the anticipation of stigma explains to a significant extent the experience of stigma, especially the beliefs that : contacts between healthy and mentally ill people are affected by negative stereotypes and therefore hindered; the mentally ill have fewer employment opportunities ; the mentally ill and healthy people cannot be partners; the mentally ill have limited access to institutionally granted benefits. 3) In our study, gender proved to be of no significance for the explanation of the indicators of stigma.

Conclusions. 1) Anticipated and experienced stigma may be explained on the basis of social, demographic and clinical factors to a limited, but significant extent. 2) The intensity of experienced stigma, to a limited but significant extent, may be accounted for by anticipation of stigma. 3) Therapeutic programmes should focus on raising self-esteem and preventing self-stigma.

schizophrenia / anticipated and experienced stigma / predictors

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INTRODUCTION

In recent years, in those countries that are involved in "Schizophrenia : Open the Doors", a WPA programme of fighting stigma and discrimination caused by the diagnosis of schizophrenia, research has been carried out by various centres on the subjective experience of stigma (INDIGO) among mentally ill people in Europe (including Poland), North and South America [1]. The number of surveyed people was 736. Answers were sought to the questions

concerning: the levels of discrimination in different countries, the areas of life where stigma is most bitterly felt and the correlations between particular demographic and clinical factors and anticipated or actually experienced discrimination. Independently of cultural differences, the results point to a relatively high level of experienced stigma and discrimination. It was found that in two important areas of life, i.e. employment and intimate relationships, anticipated stigma is more frequent than previous experience of stigma. Another finding was the relationship among increased anticipation of stigma, increased number of contacts with mental health services and the intensity of experienced discrimination [1]. Therefore, one of the conclusions from this research is the need to improve self-esteem among people suffering from schizophrenia, so that they are able to overcome self-stigma and thus to establish intimate relationships, as well as to look for and find employment.

The problem of self-esteem and self-stigma has been earnestly discussed in the recent years [2, 3, 4, 5, 6, 7, 8]. The still unanswered question is: Why are some patients more sensitive to social stereotypes and why do they internalise them so easily, why others do not ? What are the hidden, individual factors of identification with social stigma or of dismissing social stigma ? When the stigma is internalised, one has a lower self-esteem and less chance of leading an active everyday life. Therefore patients and their families, groups of therapists and researchers keep looking for the source of this strength that enables one not to submit to negative social stereotypes.

Świtaj and Wciórka [9] carried out their research on stigma and discrimination as experienced by patients in three groups: people suffering from schizophrenia, from other mental illnesses and somatic illnesses. The respective study groups were : 153 patients diagnosed with schizophrenia, 100 diagnosed with other mental disorders and 33 diagnosed with cancer and heart conditions. The experience of stigma was much more pronounced among those diagnosed with mental illnesses, especially in the area of interpersonal relationships, although the differences did not prove statistically significant.

AIM OF THE STUDY

Our previous study described the anticipation and experience of stigmatizing behaviours by mentally ill people [10]. The next step of our research was to analyse the relationships among social, demographic and clinical factors and the anticipation and experience of stigma as well as the inter-relationships between the anticipation and experience of stigmatising behaviours. The specific goals of the study were:

- analysis of anticipated and experienced stigma depending on demographic, social and clinical factors;
- analysis of the relationship among demographic, social and clinical factors, and anticipated and experienced stigma;
- analysis of the relationship between anticipated and experienced stigma.

MATERIAL AND METHOD

The study group included 202 patients from the region of Małopolska, diagnosed with schizophrenia and schizotypal disorders (ICD 10). The average age was 40 (minimum age 18, maximum age 68). The average number of hospitalizations was 6 (from 0 to 30*)*. The study group consisted of 105 (51%) men and 97 (49%) women. Angermeyer's questionnaire was used, which enabled to describe both anticipated stigma (in questions 1 – 20) and experienced stigma (in questions 21 – 40). A detailed description of this study group is to be found in our previous publication [10]. The answers to questions in part A (anticipated stigma) are arranged according to the Likert scale, and in part B (experienced stigma) there are yes/no questions. Scores for particular subscales, both in part A and in part B (e.g. the beliefs about other people's contacts with the mentally ill, or the experience of rejection, respectively), are averaged from the answers to the items included in a particular sub-scale. In either part the following rule was applied: the higher the result, the lower the stigma.

To analyse inter-group variance, Mann-Whitney U-test was used, and in the assessment of

more complex correlations multiple stepwise regression was applied.

RESULTS

The intensity of anticipated (A) and experienced (D) stigma compared in relation to demographic and clinical predictors such as : age, gender, education, place of residence, employment, marital status and the number of hospitalizations.

Presented below are only the statistically significant findings.

Gender vs. anticipated and experienced discrimination.

Within the study group, statistically significant differences were observed between men and women (Tab. 1). Women were better educated (.024) and they were more often married (.003).

The comparison (Tab. 2) shows that women more often than men think that the majority of people have a negative attitude towards the mentally ill (p.009) and so do not want to choose them as their partners (.048). No significant gender differences were found as to "experienced stigma" in any of the considered domains.

Education vs. anticipated and experienced discrimination.

A comparison was made as to the questionnaire results among people with primary and vocational education and people with secondary or higher education (Tab. 3). People with higher education:

- less frequently think that one should talk about one's mental illness openly, risking rejection, so as to gain more understanding on the part of others (.005) ;
- less frequently think that healthy people avoid contact with the mentally ill (.008);
- less frequently think one should not try to find employment because mentally ill people encounter difficulties on the labour market (.058) ;
- more frequently think that mental illness should not be revealed to the employer (.021) ;
- more frequently have met with understanding on the part of their employers, superiors and colleagues (.026) ;
- more frequently have seen films which presented a favourable image of a mentally ill person (.046).

Place of residence in relation to anticipated and experienced discrimination.

A comparison was made between questionnaire results for the inhabitants of large towns and small towns or villages (Tab. 4).
Inhabitants of large towns :

- less frequently think that one should talk about one's mental illness openly, risking rejection, so as to gain more understanding on the part of others (.022) ;
- more frequently think that the mentally ill do not get jobs although they have the same qualifications as healthy people (.21) ;
- more frequently think the employer should not be informed about one's mental illness (.012);
- more frequently have experienced a situation when the mentally ill were disparaged (.039) ;
- more frequently have seen a film in which a mentally ill person is presented in a positive manner (.044) ;

Table 1. Gender differences as to demographic and clinical predictors

Questionnaire item	Gender	N	Rank mean	Mann-Whitney U (p)
Education	Men	103	90	.024
	Women	95	109	
Marital status	Men	103	89	.003
	Women	95	110	

Table 2. Gender differences in anticipation of stigma

Questionnaire item	Gender	N	Rank mean	Mann-Whitney U (p)
I think the majority of people have a negative attitude towards the mentally ill (A – item 1)	Men	103	109	.009
	Women	95	89	
I think the majority of people do not want to have a mentally ill person as their partner (A – item 10)	Men	103	106	.048
	Women	95	92	

Table 3. Relationship between education and anticipated & experienced stigma

Questionnaire item	Education	N	Rank mean	Mann-Whitney U - (p)
1. Should one inform others about mental illness? (A – item 4)	Prim/Voc	75	86	.005
	Sec/Higher	124	109	
2. Do healthy people avoid contact with the mentally ill? (A – item 5)	Prim/Voc	75	87	.008
	Sec/Higher	124	108	
3. Should mentally ill people try to find employment? (A – item 8)	Prim/Voc	74	89	.058
	Sec/Higher	122	104	
4. Should the mentally ill inform the employer about their illness? (A – item 9)	Prim/Voc	75	88	.021
	Sec/Higher	123	107	
5. Have you ever met with understanding in the workplace? (D – item 24)	Prim/Voc	65	90	.026
	Sec/Higher	97	76	
6. Have you ever seen a mentally ill person favourably presented in a film? (D – item 35)	Prim/Voc	67	100	.046
	Sec/Higher	114	86	

Table 4. Questionnaire results for inhabitants of large towns and small towns or villages

Questionnaire item	Place of residence	N	Rank mean	Mann-Whitney U (p)
1. Should one inform others about mental illness? (A – item 4)	Small	74	88	.022
	Large	124	106	
2. Should mentally ill people try to find employment? (A – item 6)	Small	73	109	.021
	Large	124	92	
3. Should the mentally ill inform the employer about their illness? (A – item 7)	Small	73	111	.012
	Large	124	92	
4. Have you ever experienced a situation when the mentally ill were disparaged? (B – item 31)	Small	70	101	.039
	Large	114	87	
5. Have you ever seen a mentally ill person favourably presented in a film? (B – item 35)	Small	65	99	.044
	Large	115	85	

Marital status in relation to anticipated and experienced discrimination.

Various aspects of discrimination were compared for married people vs. single or separated people (Tab. 4).

What is statistically significant (p .02) is that married people less frequently think the general public blames the mentally ill for their illness. Also, married people less frequently experienced a situation when their insurance application was rejected (p .05).

Number of hospitalizations in relation to anticipated and experienced stigma.

Questionnaire results were compared for patients with a smaller number (up to 4 times)

and a higher number (more than 4 times) of hospitalizations (Tab. 6). Those who have had more hospitalizations :

- less frequently think that people blame the mentally ill for their illness (.016) ;
- more frequently feel rejected by their family members, psychiatrists, or employees of the health service ;
- more frequently have had their job application rejected when they revealed their mental illness ;
- more frequently have seen a film in which mentally ill people are shown in a negative way ;
- more frequently have experienced a situation when their rehabilitation application was rejected.

In the first stage of our research, having compared the groups it was found out that a more intense subjective sense of rejection is connected with the female gender, lower education, living in a large town and a higher number of hospitalizations, which is indicative of the severity of the course of illness.

During the next stage, it was investigated whether the obtained relationships were not influenced by other variables.

II. Relationships between social, demographic and clinical predictors and anticipated and experienced stigma.

In order to assess the relationships between social, demographic and clinical predictors and anticipated or experienced stigma, while

Table 5. Subjective experience of stigma as related to marital status

Questionnaire item	Marital status	N	Rank mean	Mann-Whitney U (p)
Considering the mentally ill guilty of their illness (A – item14d)	married	53	112	.02
	single	143	93	
Experience of rejected insurance application (B – item 37)	married	27	62	.05
	single	85	54	

Table 6. Number of hospitalizations as related to anticipated and experienced discrimination

Questionnaire item	Number of hospitalizations	N	Rank mean	Mann-Whitney U (p)
Blaming the mentally ill for their illness (A – item14d)	Up to 4	94	83	.016
	More than 4	88	101	
Experience of “general” rejection (B – item 21)	Up to 4	95	102	.001
	More than 4	87	80	
Experience of rejection by a family member (B – item 22a)	Up to 4	81	88	.007
	More than 4	77	71	
Experience of rejection by psychiatrists (B – item 22e)	Up to 4	79	80	.021
	More than 4	72	71	
Experience of rejection by health service employees (B- item 22h)	Up to 4	71	75	.016
	More than 4	68	65	
Experience of rejection of a job application when mental illness was revealed (B – item 29)	Up to 4	58	73	0.40
	More than 4	73	61	
A negative presentation of the mentally ill in a feature film (B – item 33)	Up to 4	77	86	.024
	More than 4	79	72	
Experience of a rejected rehabilitation application (B – item 39)	Up to 4	68	72	.025
	More than 4	70	67	

controlling for the remaining variables, forward stepwise regression was applied. Firstly, it was checked whether these predictors explain a statistically significant part of anticipated or experienced stigma, i.e. the variance of the dependent variable; in other words, whether they show any relationship with the dependent variable. The following predictors were subsequently examined: gender, age, education, marital status, current employment and housing, place of residence, type of received mental treatment, number of hospitalizations. Their influence on the indicators of anticipated stigma (questions 1 – 20 in part A), and on the indicators of experienced stigma (questions 21 – 40, part B) was assessed.

In the assessment of the influence on anticipated stigma, significant results were obtained for two dependant variables (stigma indicators): average negative belief concerning employment and average negative belief concerning institutions. Respectively, with regard to experienced stigma, such dependant variables were: rejection, care, experiences connected with employment and experiences connected with positive and negative images of mentally ill people in the media.

In relation to other indicators of anticipated stigma (such as interpersonal relationships, partnership, negative beliefs concerning the mentally ill) and experienced stigma (the experience of understanding, the experience of breaking contacts because of mental illness, and the experience of discrimination by institutions), forward stepwise regression did not render any statistically significant results.

The range of the variance of the dependent variables (stigma indicators) was calculated as the semi-partial correlation raised to the second power. The last stage of the research involved an analysis of correlations between anticipated and experienced stigma.

Relationships of social, demographic and clinical predictors with anticipated stigma

The significant predictor for "negative beliefs concerning employment" ($F(1.178) = 4.97$; $p < 0.027$) turned out to be "the place of residence", accounting for 272% of the variance of the dependent variable, i.e. negative beliefs concerning employment (Tab. 7).

Table 7. Relationships of social, demographic and clinical predictors with anticipated stigma in the workplace

Predictor	b	beta	r^2 * 100%	t	P
Constant	2.96			20.09	< 0.001
Place of residence	- 0.08	- 0.16	2.72	- 2.23	0.027

The subjects living in large towns more frequently stated that the mentally ill have a more difficult situation on the labour market and are excluded from it.

The significant predictor for the dependent variable named "belief about impaired access to public institutions" (indicator of structural discrimination; $F(1.177) = 12.60$; $p < 0.001$) was subjects' age, which accounted for 6.65% of the variance (Tab. 8.).

Table 8. Relationships of social, demographic and clinical predictors with anticipated stigma in public institutions (average negative belief concerning institutions)

Predictor	b	beta	r^2 * 100%	t	P
Constant	3.83			11.59	< 0.001
Age	- 0.03	- 0.26	6.65	- 3.55	< 0.001

Older people more frequently claimed that the mentally ill have a more difficult access to institutions.

Relationships of social, demographic and clinical predictors with the experienced stigma

The significant predictor for "the experience of rejection in interpersonal relationships"

($F(1.166) = 5.08$; $p < 0.025$) is the number of hospitalizations, accounting for 2.95% of the variance (Tab. 9).

Those who had been more often hospitalized, more frequently experienced rejection.

The significant predictor for "the experience of care" was the number of previous hospitalizations ($F(1.168) = 4.59$; $p < 0.034$), accounting for 2.66% of the variance of the dependent variable, that is the average experience of being taken care of by others (Tab. 10).

Table 9. Relationship of social, demographic and clinical predictors with the experience of rejection in relationships (average negative experience)

Predictor	b	beta	r^2 * 100%	T	P
Constant	0.23			6.84	< 0.001
Number of hospitalizations	0.01	0.17	2.95	2.25	0.025

Table 10. Relationships of social, demographic and clinical predictors with the "experience of being taken care of in interpersonal relationships"

Predictor	b	beta	r^2 * 100%	t	P
Constant	0.40			10.13	< 0.001
Number of hospitalizations	0.01	0.16	2.66	2.14	0.034

Just as they experienced more rejection, those who had been hospitalized more often also more frequently experienced care of other people.

The significant predictor which was related to "experiencing stigma while seeking employment" ($F(1.127) = 7.02$; $p < 0.009$) was the number of hospitalizations, accounting for 5.24% of the variance of the dependant variable (average negative experience of revealing mental illness while getting a job) (Tab. 11).

Table 11. Relationship of social, demographic and clinical predictors with the experience of stigma in the workplace

Predictor	b	beta	r^2 * 100%	t	P
Constant	0.29			4.71	< 0.001
Number of hospitalizations	0.02	0.23	5.24	2.65	0.009

Those who had been more frequently hospitalized, more often claimed that they did not get a job because of their mental illness.

For "the experience of a negative media image of a mentally ill person" the significant predictor was current professional activity ($F(1.163) = 7.28$; $p < 0.008$), which accounted for 4.28% of the variance (Tab. 12).

Those who are unemployed or receive disability benefit more frequently noticed a negative image of a mentally ill person in the media.

Two predictors explained the variance of "experiencing a positive media image of a mentally ill person", that is: education ($F(2.172) = 4.82$; $p < 0.009$) and the number of hospitalizations ($F(2.172) = 4.82$; $p < 0.009$), accounted for 5.68% of the variance of (Tab. 13).

Table 12. Relationship of social, demographic and clinical predictors with the experience of a negative media image of a mentally ill person

Predictor	b	beta	r^2 * 100%	t	P
Constant	0.75			7.53	0.001
Professional activity*	- 0.19	- 0.21	4.28	- 2.70	0.008

** Professional activity is the activity of people who work full- or half-time or get vocational education.*

Table 13. Relationship of social, demographic and clinical predictors with the experience of a positive media image of a mentally ill person

Predictor	b	beta	r^2 * 100%	t	P
Constant	0.37			3.45	0.001
Education	0.04	0.18	3.06	2.36	0.019
Number of hospitalizations	0.01	0.16	2.62	2.18	0.031

People who were better educated and those who had been less often hospitalized more frequently perceived the media image of a mentally ill person as a positive one.

Summing up the findings of the second stage of our research, one can state that of the investigated social, demographic and clinical predictors only "older age" and "living in a large town" account for the stigma anticipated by the surveyed, though to a limited extent. As to the experience of stigma caused by mental illness, it is intensified, also to a limited but significant extent, by better education, lack of employment, and a higher number of previous hospitalizations. So, every one of the studied areas of stigmatisation is connected with a different constellation of factors, and more advanced analyses do not show any relationship between gender and the indicators of anticipated or experienced stigma in our research.

III. The relationship between anticipated and experienced stigma

The next stage of research pertained to the influence of anticipated stigma on experienced stigma. The indicators of anticipated stigma (part A of the questionnaire, questions 1-20) were used as the prognostic factors. Initially, it was checked whether all the prognostic factors account for a statistically significant part of the variance of the dependant variable, in other words, whether these predictors are at all correlated with the dependent variable (i.e. indicators of experienced stigma, part B of the questionnaire, questions 21 – 40).

Described below are the significant results of stepwise regression analysis for the indicators of experienced stigma such as the experience of rejection in interpersonal contacts, of breaking contact, the experience of care, of an unpleasant situation in interpersonal contact, of a negative or positive media image of a mentally ill person and the experience of contact with institutions. As the prognostic factors the indicators of anticipated stigma in the following areas were used: interpersonal contacts, employment, partnership, opinions about the mentally ill and contacts with institutions. At the outset, it was checked whether all the prognostic factors account for a statistically significant part of the variance of the dependant variable.

The predictor that accounted for 5% of the "experience of rejection" was the "belief about the impossibility of partnership with a mentally ill" ($F(1.177) = 10.1$; $p = 0.002$).

Table 14. Relationship between anticipated stigma and the "experience of rejection"

Predictor	B	beta	r^2 * 100%	T	p
Constant	0.55			6.55	< 0.001
Belief about the impossibility of being partners	- 0.08	- 0.23	5.0	-3.18	0.002

Those who were more strongly convinced that mentally ill people cannot be partners for healthy people experienced rejection less frequently (Tab. 14).

The significant predictor ($F(1.172) = 5.28$; $p = 0.023$), accounting for 7% of the variance of the "experience of breaking contact because of mental illness", was the anticipation of difficulty in contact (Tab. 15).

Table 15. Relationship between anticipated stigma and the "experience of breaking contact because of mental illness"

Predictor	B	beta	r^2 * 100%	T	P
Constant	0.18			2.35	< 0.001
Belief about the mentally ill as having difficulty in interpersonal contact	0.11	0.26	7.0	3.68	0.023

Those who were convinced that mentally ill people have difficulty in interpersonal contacts more frequently experienced a situation when the contact was broken.

The significant predictor ($F(1.179) = 13.56$; $p < 0.001$), accounting for 7% of the variance of the "experience of care", was the belief that mentally ill people experience difficulty of contact in interpersonal relationships (Tab. 16).

Table 16. Relationship between anticipated stigma and the experience of care in a relationship

Predictor	b	beta	r^2 * 100%	t	P
Constant	0.18			2.35	0.020
Belief about difficulty in interpersonal contact	0.11	0.26	7.0	3.68	< 0.001

Those who thought the mentally ill have difficulty in interpersonal contacts more often experienced care in a relationship.

The significant predictor ($F(1.184) = 13.18$; $p < 0.001$) of the indicator named "an unpleasant experience in interpersonal contacts" was the belief about limited opportunities of employment. It accounts for 7% of the variance of the dependent variable (Tab. 17).

Table 17. Relationship between anticipated stigma and "an unpleasant situation experienced in interpersonal relationships"

Predictor	b	beta	r^2* 100%	t	P
Constant	0.95			10.27	< 0.001
Belief about limited employment opportunities	- 0.12	- 0.26	7.0	- 3.63	< 0.001

Those who thought the mentally ill encounter limitations on the labour market more often reported an unpleasant situation in interpersonal relationships.

The constellation of three predictors: belief about a limited access to institutions, belief about limited employment opportunities and belief about the impossibility of partnership ($F(3.171) = 8.81$; $p < 0.001$), account for 13.6% of the variance of the dependent variable, i.e. "an experience of a negative media image of a mentally ill person" (Tab. 18).

Table 18. Relationship between anticipated stigma and "the experience of a negative media image of a mentally ill person"

Predictor	b	Beta	r^2 * 100%	T	P
Constant	0.78			5.88	< 0.001
Belief about impaired access to institutionally granted benefits	- 0.10	- 0.27	5.8	- 3.39	0.001
Belief about fewer employment opportunities	- 0.12	- 0.23	4.6	- 3.63	0.003
Belief about the impossibility of partnership	0.10	0.20	3.2	0.01	0.013

Those respondents who more often stated that the mentally ill have a restricted access to the benefits that are distributed institutionally, that they encounter more difficulties on the labor market and that they cannot have relationships with healthy people more often reported that the media present a negative image of mentally ill persons.

Another significant predictor ($F(1.182) = 7.75$; $p = 0.006$), accounting for 4.1% of the variance of "an experience of a positive media image of a mentally ill person", was the belief about a negative stereotype pervading contacts with the mentally ill (Tab. 19).

Table 19. Relationship between anticipated stigma and the experience of a positive media image of a mentally ill person

Predictor	B	beta	r^2 * 100%	T	p
Constant	0.41			4.49	< 0.001
Belief about negative stereotypes in interpersonal contacts of mentally ill with healthy people	0.10	0.20	4.1	2.78	0.006

The less frequent was the respondents' opinion that contacts between mentally ill and healthy people are marked by negative stereotypes, the more frequently they reported a positive media image of a mentally ill person.

The significant predictor ($F(1.169) = 13.55$; $p < 0.001$), accounting for 7.3% of the variance of the dependent variable named "impaired contact with institutions" was the belief about the restricted access to the benefits granted by those institutions (Tab. 20).

Table 20. Relationship between anticipated stigma and the "experienced difficulties in contacts with institutions"

Predictor	B	beta	r^2 * 100%	t	p
Constant	0.23			5.60	< 0.001
Belief about impaired access to institutions	- 0.05	-0.27	7.3	-3.68	< 0.001

Those respondents who claimed that the mentally ill have restricted access to benefits distributed by institutions more frequently reported difficulty in contact with institutions.

This part of the research seeking the relationship between anticipated and experienced discrimination shows that a limited but significant part of experienced stigma may be explained by the anticipation of stigma, especially by the beliefs that contacts with mentally ill people are marked by negative stereotypes and therefore hindered, that the mentally ill have limited job opportunities, that it is impossible for a mentally ill person to be a partner of a healthy person, that the mentally ill have restricted access to benefits granted by institutions.

Comments on the findings and discussion

The purpose of the study was (i) to assess the stigma which was anticipated and experienced by people suffering from schizophrenia and undergoing treatment in various mental health institutions in the Malopolska region; (ii) to analyse internal relationships between selected demographic and clinical predictors; and (iii) to analyse their influence on the obtained results. The study group included mostly older patients who have been ill for many years and have got a wide range of experiences in their contact with mental health services. The findings from inter-group comparisons show that the sense of stigmatization is stronger in women, in people who have primary or vocational education, in those who live in large towns and in those who were more often hospitalized, which is an indicator of the severity of their illness.

Women, as compared to men, are better educated, have a wider professional experience, and they are more often married. The described gender differences, implying better so-

cialization connected with the age at the onset of the illness [11, 12], are observed throughout the years of living with the illness. Gender comparisons show that women feel the stigma more intensely. This may stem from the fact that women ascribe a great value to a relationship, having a partner and children. In our research, women more often than men stated that healthy people do not want to have a relationship with a person who has suffered from mental illness. The research conducted by Thara et al. [13] in India shows that for women forming and maintaining their marriage is a key value in life. They surveyed 76 women diagnosed with schizophrenia and enquired how much the foundering of their marriage, doubling the burden of their diagnosis of schizophrenia, was the cause of their discrimination by the local community. The hypothesis was confirmed: for those women separation was as much a disgrace as their diagnosis. The majority of them still hoped that their husbands, their partners would return to them. It seems that differences between studies are resulting from a cultural factor: the meaning of the institution of marriage. Working in a different cultural milieu, Camp, Finley and Lyons [5] obtained different results. They researched a relationship between low self-esteem and the resulting stigma in 10 chronically ill women. An important factor influencing self-esteem proved to be an individual understanding of a woman's social role and its impact on her self-image. The surveyed women accepted their problems with mental health and dismissed a negative stereotype of a mentally ill person, striving to contradict that stereotype. Obviously, cultural differences are pivotal in research on stigma. However, the next stage of research, during which stepwise regression analysis was applied, did not corroborate the notion that gender influences the subjective sense of stigma.

Education is a predictor that throughout the years of suffering from schizophrenia may have an impact even on those treatment outcomes that are distant in time. Comparisons between groups lead to the conclusion that people with higher education have better strategies of coping with the illness, have better social skills of prudent camouflage, they tend to conceal their illness, also to protect themselves from the employer on the free labour market. They tend rather not to speak openly about their illness so as to avoid the stigma and potential rejection. At the same time, they think healthy people do not shun them, that one should work despite mental illness, and they more often meet with friendly attitudes in the workplace. Additionally, they more often notice a positive media image of a mentally ill person. Education proves to be a significant factor both in simple comparisons between groups and in stepwise regression analysis.

Those who live in **large towns** are more often convinced the attitudes of the general public are critical and dismissive. That is the conclusion from inter-group comparisons and from stepwise regression analysis concerning the factors that influence anticipation of stigma in employment. The belief that mental illness excludes one from the labour market is the reason why inhabitants of large towns more often hide the fact they are ill. For the mentally ill, employment is a primary indicator of their return to the community [12, 15], and the difficulties involved are obvious. Yet, as the same respondents admit, they more often see a positive representation of a mentally ill person in the media. A possible explanation is that a smaller community (a small town or a village) may accept more easily a mentally ill person on condition that this community upholds the cultural model of caring for somebody who is weaker or different, but still belongs to the community. Larger towns are more anonymous communities and have weaker local bonds, so a weaker or different person may be perceived as a stranger and rejected. Whether this is precisely the case in Poland should be more deeply investigated in current sociological research. For instance Germany, where Angermeyer's results proved to the contrary [16], appears to be quite dissimilar. There, respondents who live in small towns more often anticipated discrimination than people who live in large towns, although the level of experienced discrimination was the same. The significance of a small local community and its advantages over anonymous large towns were convincingly presented by Klaus Dörner. He enumerated the assets of

"rural psychiatry" and stated that the therapeutic culture of a large town, which was predominant in the past century, has to undergo now, so to speak, its own therapy since it had forgotten the traditions and values cherished by small local communities [17].

Other findings show that a more severe course of the illness, as indicated by a **higher number of hospitalizations**, involves a more intense experience of stigma. In this respect, the results obtained through inter-group comparison and through stepwise regression analysis are convergent. First of all, the more severely ill are more frequently rejected, both by their relatives and by psychiatrists and the national health service. A particularly painful finding is the rejection by psychiatrists, demonstrated also in international research [18]. Similarly, Ertugrul and Ulug's study[19] showed a correlation between stigmatization as experienced by the mentally ill and the intensity of psychopathological symptoms and more severe course of the illness. In particular, severe depression, hallucinations, suspiciousness as well as social and emotional withdrawal are the predictors of a more intensely perceived stigmatization. Also Thornicroft [18] found a correlation between experienced sigma and the frequency of contact with mental health service as an indicator of the severity of the illness.

American researchers, Dickerson et al. [20], working with a study group of 75 people diagnosed with schizophrenia, demonstrated a correlation between socio-economic conditions and the scope and intensity of sigma. These socio-economic conditions were assessed on the basis of the professional status of the patient's parent (the information was provided by the surveyed); the parents' professional status was correlated to a significant extent with the degree of discrimination - the higher the status, the stronger was the experience of discrimination. While interpreting the phenomenon, other authors quote Angermayer's opinion that a higher social and economic status makes patients more conscious of what they can lose or what they have just lost because of their mental illness [20, p. 152].

In our study, concerning the Małopolska region, those patients who were more often hospitalized stress the problems on the labour market. They also think mental patients are discriminated by institutions. Similar results were obtained via analysis of the influence of demographic and clinical predictors on the experience of stigma. Those respondents who were more often hospitalized were also more often rejected and more often were refused job positions because of their mental illness. So a severe course of the illness, with many relapses, involves a strong sense of being rejected and the impossibility of finding employment. It seems that relapses and recurring re-hospitalizations take away hope and account for the self-stigma in people suffering from schizophrenia. The patients themselves think their place is on the margins of society. To overcome this stereotype is the most daunting challenge faced by the patients, their families and therapists.

Thornicroft et al. carried out comprehensive research embracing many centres and found a correlation between anticipated discrimination and experienced stigma. However, they did not assess the degree of influence [18] and just noted the presence of significant correlations.

The most important area of the respondents' negative experience are interpersonal relationships [10, 18]. In our study those who **anticipated** impaired interpersonal contacts and problems with finding a job, **more often experienced** broken ties and more often reported unpleasant situations in interpersonal contacts. Nonetheless, the beliefs of the patients turned out to be somewhat inconsistent: those who claimed that it is impossible for a healthy person to take a mentally ill person for a partner had fewer experiences of being rejected. Moreover, those respondents who thought the mentally ill have impaired interpersonal contacts, **more often experienced** care on the part of other people. Self-stigma, among others, may be either the cause or consequence of such beliefs. It seems, anyway, that these issues should be more deeply probed in research and reflection and seen against a wider background.

An interesting and valuable finding concerns the enormous role of the **mass media** in shaping the beliefs of the mentally ill and in their

anticipation of stigma. Both on inter-group comparisons and stepwise regression analyses, the relationship between the media and anticipated and experienced stigma is a significant one. While reading papers, listening to the radio or watching TV, the respondents encountered either positive or negative images of a mentally ill person and that affected their beliefs. The analysis of correlations between anticipated and experienced stigma points to the following: 1/ those who claimed that the mentally ill have a limited access to the benefits distributed by institutions perceived a negative image of a mentally ill person in the media; 2/ those who anticipated difficulties on the labour market more often observed negative media images of mentally ill people ; 3/ those who stated that the mentally ill may have relationships with the healthy, more often reported negative media images of the mentally ill; 4/ those who tended not to claim that contacts between healthy people and mentally ill people are affected by negative stereotypes more often reported to have seen a positive media image of a mentally ill person.

The self-esteem of an ill person is drastically reduced at the outbreak of psychosis and then in the chronic course of the illness. From the very beginning of inpatient treatment provided to a schizophrenia-diagnosed person, self-esteem should be one of the main issues in psychotherapy. Lowered self-esteem and fossilized beliefs appear to be related to mass media images of mentally ill people, encountered while watching, reading or listening to media messages.

Self-stigma influences the experience of discrimination that is reported by the studied persons. Self-stigma, or rather internalized stigma, is more profoundly addressed in the Polish publication "Umacnianie nadzieja czy uprzedzenia". The authors stress that the perception of oneself changes when a negative social stereotype is adopted, and the change in a fundamental way affects the functioning of a mentally ill person. The consequences are loss of hope, lack of motivation to undertake any activity, increased anxiety in interpersonal contacts and ensuing withdrawal from the community [21]. In research on social stigma, the problem of self-esteem and self-stigma of stigmatized people appears to be of immense importance [3, 7]. Low self-esteem inevitably accompanies discrimination experienced by mentally ill people. Studies on self-esteem in various discriminated populations show large individual differences. Crocker and Quinn think these differences have three sources : 1/ stigmatized people *en masse* do not internalize the negative image of themselves [22, p. 153] ; 2/ self-esteem may change with time ; 3/ changes in self-esteem may occur when new important information appears or when an important event takes place in somebody's life [22]. The authors do not consider self-esteem as a stable personal characteristic but rather as a construct that depends on the circumstances and on the significance the "I" ascribes to these circumstances. Even if the illness lasts for a long time, when positive assumptions are made, then it is easier to think in a positive, optimistic way and to act so as to overcome stigma and self-stigma. In a similar manner, some British researchers assessed the effect of group therapy on experienced stigma and self-esteem in schizophrenia-diagnosed people. The therapy was based on a cognitive and behavioural approach and brought the expected results: the patients' self-esteem was raised while both the positive and negative symptoms were reduced [23]. The clinical practice of providing psychotherapy to mentally ill people, applied for thirty years by Cracow's psychologists and psychiatrists, confirms the above-described findings and the purposefulness of our effort to include psychotherapy in standard treatment programs intended for people suffering from schizophrenia.

Empowerment, giving hope, and seeking recovery are constantly present in the therapy and rehabilitation of the mentally ill. More and more discussed issues find their way to the awareness of the general public [2]. In Poland, activities to prevent stigma are undertaken in the social campaign "Schizophrenia: Open the Doors", and they are most easily noticeable during the Day of Solidarity with Mentally Ill People. Within the program, educational projects are offered to various social groups. The objectives of the program are to increase tolerance and understanding toward people suffering from mental health problems, to reduce

fear and to modify negative stereotypes. It is critical for the program not to include such activities that could stifle stigmatizing responses. As ever, this could have harmful emotional, cognitive and behavioural consequences such as ambivalence, anxiety, avoidance of the mentally ill. The outcomes could be the opposite to what is awaited and we could even observe a "boomerang effect" [22].

There are various strategies of modifying social stigma such as "protest, education and contact" [21, p. 63]. Research on the modification of stigma proves that the most efficient method is "contact", meaning simple direct contact with ill people, which brings about more understanding for them. Education is also needed, but it should not stand on its own: the best results were obtained when it was joined with direct contact, as it is practised by the Cracow association of patients called "Open the Doors" [24]. Such projects are carried out within the national program "Schizophrenia : Open the Doors", supervised by the Board of the Polish Psychiatric Association.

It is our strong belief that a program which is to oppose discrimination against the mentally ill should not be intrusive – instead, it should involve ill people in the process of educating the public so that we can listen to the stories of those who managed to overcome the illness, to overcome stereotypes and who live among us, with us.

CONCLUSIONS

- To a limited, but significant extent the more intense anticipation and experience of stigma may be accounted for by such social, demographic and clinical predictors as the old age, living in a large town, better education, no employment and a higher number of previous hospitalizations.
- To a limited, but significant extent the experience of stigma may be accounted for by anticipation of stigma.
- Therapeutic programs should focus on raising self-esteem and preventing self-sigma.

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